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ABSTRACT

A humanistic ideology which emphasizes self-determination, self-reliance, and personal responsibility in decision making, is congruent with the goal of community psychiatry to integrate the ex-institutionalized psychiatric client in the community. The following applications of this ideology in a small community mental health center are described: (a) development of client advisory boards; (b) client selection of available services; (c) client involvement in problem defining, goal setting, and goal attainment rating; (d) "demythologizing" seminars for ex-institutionalized clients; (e) staff efforts to reduce manipulative-dependent client behaviors; and (f) explication, through contracting, of the decision rules regarding involuntary hospitalization. (Author)

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# Humanistic Approaches in the Delivery of Community Mental Health Services

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# Humanistic Approaches in the Delivery of Community Mental Health Services

Erickson (1957) has suggested that community psychiatry may actually impede the ex-hospitalized patient's progress toward independent community living by providing a setting in which patient or "sick" roles remain functional. When released to the community, the ex-hospitalized patient is often faced with the need to supplant the set of patient stereotypic role-enactments encouraged by the milieu of the hospital (Barton, 1959; Goffman, 1961) with role-enactments more appropriate to self-reliant, independent living. However, the community psychologist often faces the paradox of attempting to promote his clients' independent role functioning within the context of a medical model ideology which implicitly rejects client self-determination and personal responsibility. The client is not seen as responsible for his/her "aberrant" behavior, since, according to the model, it issues from an illness or disease. A humanistic approach, which treats all persons as self-responsible creating agents, rather than as mediators of causal linkages (Nevid, Note 1), is more concordant with the community psychiatry effort to promote the independent functioning of ex-institutionalized "mental patients".

To effect the change from dependent and helpless patient type behaviors to full citizenry role-enactments, the clinic staff of a small state supported community satellite clinic have attempted, in the following ways, to encourage their clients toward self-reliance and acceptance of personal responsibility in decision making. First, the clinic's staff regard psychiatric clients as consumers capable of evaluating the services they receive, rather than as passive recipients of "treatment". A client advisory board has been established to encourage clients to evaluate ongoing clinic programs and services, and to assist staff in the development of new programs (Morrison, 1976a). At the individual case level, the clinic offers

clients a booklet describing the available therapeutic, educational, and vocational programs. This booklet allows the client-consumers, in consultation with their therapists, to make informed decisions regarding their most appropriate service plans. In addition, clients have become involved in the problem defining, goal setting, and goal attainment rating aspects of treatment planning and evaluation (Nevid, Morrison, Gaviria & Rathus, 1976). The clients' involvement in planning and evaluating their treatment serves to focus attention on their active role in the therapeutic process. Otherwise, if clients continue to construe treatment as something defined, planned, and evaluated for them, their passive-dependent patient roles may remain intact.

Part and parcel of the attempt to foster a therapeutic milieu which encourages clients toward independent role functioning, many of the clinic's ex-institutionalized clients have been exposed to "demythologizing" seminars (Morrison, 1976b; Morrison & Nevid, 1976). These 4-12 session seminars provide a forum for presentation of the "demythologizing" position (e.g., "the myth of mental illness") identified with the writings of Szasz (1970, Sarbin & Mancuso (1970) and Laing (1972). Psychiatric clients, often exposed to a medical model orientation by institutional caregivers, may have learned to construe their behavior as an inexorable consequence of their "pathology". The "demythologizing" approach attempts to supplant this expectation with the expectation that clients can exercise choices and assume responsibility for seeking behavioral solutions to their present problems.

The telephone often becomes a prime instrument through which clients may engage in dependent role-enactments and manipulate for attention (Brockopp, 1970). "Nuisance" calls from clients seeking to avoid personal responsibility for decision making are familiar to most clinicians engaged in providing aftercare services. To encourage independent role functioning, withdrawal of social reinforcement was made contingent on clearly defined manipulative-

dependent telephoning behavior of several extremely manipulative-dependent clients in a pilot study (Morrison, Fasano, Becker & Nevid, in press). This A-B-A type self-controlled study demonstrated the effectiveness of this procedure in decreasing manipulative-dependent telephoning behavior. To increase the clients' repertoire of more adaptive self-reliant behaviors, special workshops in developing problem solving skills were offered.

In order to decrease the ex-hospitalized client's fear of arbitrary psychiatric commitment actions, contracts have been used to provide tangible assurances against such practices (Nevid & Morrison, Note 2). These individually tailored contracts delineate those client behaviors (e.g., disagreements with family, hallucinatory experiences), however socially undesirable, not considered as necessitating involuntary hospitalization. Such contracts, signed by family members and clinic staff, are considered to be morally and legally binding on the parties involved. By bringing into the open the often covert decision rules for psychiatric commitment, the psychiatric milieu should be less threatening to the client. This contracting approach also encourages clients to accept responsibility for their behavioral excesses (e.g., threats or acts of violence to self or others) which void the contract.

Further efforts to "humanize" the delivery of clinic services are in progress. At present, consideration is being given to a proposal to allow clients access to their "confidential" psychiatric records. Finally, attempts are also being made to revise diagnostic procedures to avoid the use of stigmatizing labels (e.g., increased use of "diagnosis deferred" category).

## Reference Notes

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